



**STATE HOME PROGRAM APPLICATION FOR VETERAN CARE  
MEDICAL CERTIFICATION**

**PART I - ADMINISTRATIVE**

STATE HOME FACILITY		DATE ADMITTED	GENDER <input type="checkbox"/> M <input type="checkbox"/> F
RESIDENT'S NAME (Last, First, Middle) (This is a mandatory field)		SOCIAL SECURITY NUMBER. (Mandatory field)	
RESIDENT'S STREET ADDRESS		AGE	DATE OF BIRTH (mm/dd/yyyy)
CITY, STATE AND ZIP CODE		ADVANCED MEDICAL DIRECTIVE <input type="checkbox"/> NO <input type="checkbox"/> YES	

**PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary)**

HISTORY

HEIGHT	WEIGHT	TEMP	PULSE	BP	HEAD/EYES/EAR/NOSE AND THROAT
NECK				CARDIOPULMONARY	
ABDOMEN				GENITOURINARY	
RECTAL				EXTREMITIES	
NEUROLOGICAL				ALLERGY/DRUG SENSITIVITY	

X-RAY/ LAB	CHEST X-RAY	DATE (mm/dd/yyyy)	RESULTS	CBC	DATE (mm/dd/yyyy)	RESULTS
	SEROLOGY					
	URINALYSIS	DATE (mm/dd/yyyy)	ALBUMEN	SUGAR	ACETONE	

CHECK ALL BOXES THAT APPLY OR CHECK NA

IS DEMENTIA THE PRIMARY DIAGNOSIS <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THERE A DIAGNOSIS OF MENTAL ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO	HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS <input type="checkbox"/> YES <input type="checkbox"/> NO	IS CLIENT A DANGER TO SELF OR OTHERS <input type="checkbox"/> YES <input type="checkbox"/> NO
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IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:

<input type="checkbox"/> SCHIZOPHRENIA	<input type="checkbox"/> PARANOIA	<input type="checkbox"/> OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY
<input type="checkbox"/> MOOD SWINGS	<input type="checkbox"/> SOMATOFORM DISORDER	<input type="checkbox"/> PANIC OR SEVERE ANXIETY DISORDER
		<input type="checkbox"/> PERSONALITY DISORDER

<b>OXYGEN</b> <input type="checkbox"/> MASK <input type="checkbox"/> PRN <input type="checkbox"/> NASAL CANULAR <input type="checkbox"/> CONTINUOUS	<input type="checkbox"/> TUBE FEEDING <input type="checkbox"/> OSTOMY <input type="checkbox"/> TRACHOSTOMY	<input type="checkbox"/> DECUBITUS ULCERS <input type="checkbox"/> DRAINING WOUND <input type="checkbox"/> WOUND CULTURED	<b>FOLEY CATHETER</b> <input type="checkbox"/> TEMPORARY <input type="checkbox"/> PERMANENT
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REFERRING PHYSICIAN	PRIMARY DIAGNOSIS
SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS

**TYPE OF CARE RECOMMENDED:**  SKILLED NURSING HOME CARE  DOMICILIARY CARE  ADULT HEALTH CARE  HOSPITAL

MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY

PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED	SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED
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**STATE HOME PROGRAM APPLICATION FOR VETERAN CARE - MEDICAL CERTIFICATION, CONTINUED**

RESIDENT'S NAME (Last, First, Middle)

SOCIAL SECURITY NUMBER

**EVALUATION (Select an appropriate number in each category)**

<b>COMMUNICATION</b>	<input type="checkbox"/> 1. Transmits messages/receives information <input type="checkbox"/> 2. Limited ability <input type="checkbox"/> 3. Nearly or totally unable	<b>SPEECH</b>	<input type="checkbox"/> 1. Speak clearly with others of same language <input type="checkbox"/> 2. Limited ability <input type="checkbox"/> 3. Unable to speak clearly or not at all
<b>HEARING</b>	<input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Hearing slightly impaired <input type="checkbox"/> 3. Nearly or totally unable <input type="checkbox"/> 4. Virtually/completely deaf	<b>SIGHT</b>	<input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Vision adequate - Unable to read/see details <input type="checkbox"/> 3. Vision limited - Gross object differentiation <input type="checkbox"/> 4. Blind
<b>TRANSFER</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Equipment only <input type="checkbox"/> 3. Supervision only <input type="checkbox"/> 4. Requires human transfer w/wo equipment <input type="checkbox"/> 5. Bedfast	<b>AMBULATION</b>	<input type="checkbox"/> 1. Independence w/wo assistive device <input type="checkbox"/> 2. Walks with supervision <input type="checkbox"/> 3. Walks with continuous human support <input type="checkbox"/> 4. Bed to chair (total help) <input type="checkbox"/> 5. Bedfast
<b>ENDURANCE</b>	<input type="checkbox"/> 1. Tolerates distances (250 feet sustained activity) <input type="checkbox"/> 2. Needs intermitten rest <input type="checkbox"/> 3. Rarely tolerates short activities <input type="checkbox"/> 4. No tolerance	<b>MENTAL AND BEHAVIOR STATUS</b>	<input type="checkbox"/> 1. Alert <input type="checkbox"/> 2. Confused <input type="checkbox"/> 3. Disoriented <input type="checkbox"/> 4. Comatose <input type="checkbox"/> 5. Agreeable <input type="checkbox"/> 6. Disruptive <input type="checkbox"/> 7. Apathetic <input type="checkbox"/> 8. Well motivated
<b>TOILETING</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Assistance to and from and transfer <input type="checkbox"/> 3. Total assistance including personal hygiene, help with clothes <input type="checkbox"/> A. Bathroom <input type="checkbox"/> B. Bedside commode <input type="checkbox"/> C. Bedpan	<b>BATHING</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Supervision Only <input type="checkbox"/> 3. Assistance <input type="checkbox"/> 4. Is bathed <input type="checkbox"/> A. Tub <input type="checkbox"/> B. Shower <input type="checkbox"/> C. Sponge bath
<b>DRESSING</b>	<input type="checkbox"/> 1. Dresses self <input type="checkbox"/> 2. Minor assistance <input type="checkbox"/> 3. Needs help to complete dressing <input type="checkbox"/> 4. Has to be dressed	<b>FEEDING</b>	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Minor assistance, needs tray set up only <input type="checkbox"/> 3. Help feeding/encouraging <input type="checkbox"/> 4. Is fed
<b>BLADDER CONTROL</b>	<input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Rarely incontinent <input type="checkbox"/> 3. Occasional - once/week or less <input type="checkbox"/> 4. Frequent - up to once a day <input type="checkbox"/> 5. Total incontinence <input type="checkbox"/> 6. Catheter, indwelling	<b>BOWEL CONTROL</b>	<input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Rarely incontinent <input type="checkbox"/> 3. Occasional - once/week or less <input type="checkbox"/> 4. Frequent - up to once a day <input type="checkbox"/> 5. Total incontinence <input type="checkbox"/> 6. Ostomy
<b>SKIN CONDITION</b>	<input type="checkbox"/> 1. Intact <input type="checkbox"/> 2. Dry/Fragile <input type="checkbox"/> 3. Irritations (Rash) <input type="checkbox"/> 4. Open wound <input type="checkbox"/> 5. Decubitus                 Number _____ Stage _____	<b>WHEEL CHAIR USE</b>	<input type="checkbox"/> 1. Independence <input type="checkbox"/> 2. Assistance in difficult maneuvering <input type="checkbox"/> 3. Wheels a few feet <input type="checkbox"/> 4. Unable to use <input type="checkbox"/> NA

SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN

DATE

**PHYSICAL THERAPY (To be completed by Physical Therapist or Referring Physician)**  NEW REFERRAL  CONTINUATION OF THERAPY

SENSATION IMPAIRED	RESTRICT ACTIVITY	PRECAUTIONS	FREQUENCY OF TREATMENT
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> CARDIAC <input type="checkbox"/> OTHER (Specify)	

**TREATMENT GOALS:**  ACTIVE  COORDINATING ACTIVITIES  FULL WEIGHT BEARING  WHEELCHAIR INDEPENDENT  
 STRETCHING  ACTIVE ASSISTIVE  NON-WEIGHT BEARING  PROGRESS BED TO WHEELCHAIR  COMPLETE AMBULATION  
 PASSIVE ROM  PROGRESSIVE RESISTIVE  PARTIAL WEIGHT BEARING  RECOVERY TO FUL FUNCTION

ADDITIONAL THERAPIES	SIGNATURE OF AND TITLE OF THERAPIST	DATE
<input type="checkbox"/> O.T. <input type="checkbox"/> SPEECH <input type="checkbox"/> DIETARY		

**SOCIAL WORK ASSESSMENT (To be completed by Social Worker)**

PRIOR LIVING ARRANGEMENTS	LONG RANGE PLAN
ADJUSTMENT TO ILLNESS OR DISABILITY	SIGNATURE OF SOCIAL WORKER
	DATE

**VA AUTHORIZATION FOR PAYMENT**

DATE RECEIVED BY VA	ELIGIBILITY FOR PER DIEM PAYMENT	LEVEL OF CARE RECOMMENDED
	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	<input type="checkbox"/> NHC <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ADHC
REASON FOR DISAPPROVAL	<input type="checkbox"/> APPROVED	REASON FOR DISAPPROVAL
	<input type="checkbox"/> DISAPPROVED	
SIGNATURE OF VA OFFICIAL	DATE	SIGNATURE OF VA PHYSICIAN
		DATE

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